Mental Health Newsletter

DEPARTMENT OF PUBLIC WELFARE

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Editorially Speaking

National Service Corps Transcends Partisan Issues...

Bill number S. 1321 on the National Service Corps, often popularly referred to as the "Domestic Peace Corps," is now before the Congress of the United States.

It is hard to comment on the bill without entering into some issues of controversy. One division of opinion is generally along partisan lines, around the issue of federal-state relations, and participation by the federal government in areas of local or private responsibility. It is not appropriate or intended by this Newsletter to enter into partisan political debate. Neither of our comments is intended to either clarify or confuse the issues of federal and state relationships. The question of the National Service Corps can be dealt with on other levels.

Certainly this particular bill is not the first one concerning mental health that has posed problems of federal-state relations. The history of federal-state co-participations in the broader areas of health and welfare considerably antedate mental health activities as such. The problem of federal and state sovereignties and responsibilities is as old as the Constitution, and the tensions, cleavage lines, and points of mutual facilitation are not only a continuing source of weakness or strength for the nation, but also a study of perpetual interest and concern to the political scientist and average citizen alike.

Other objections to the National Service Corps have been voiced. For example, jurisdictional anxiety concerning entry of outside-sponsored personnel into existing establishments, and all the problems of xenophobia, differing loyalties and identifications, and organizational discipline that this may entail. It has been argued that there is no real analogy between foreign and domestic service, and that the success of the overseas Peace Corps is not immediately or even ultimately transferable. There have been some semantic problems over the definition of "volunteer". It has been pointed out that this will not solve manpower problems in mental institutions and that it should not attempt to substitute for regular personnel nor seduce state legislatures into a relinquishment of their responsibility. Arguments as one actually hear them vary not so much in their intrinsic validity as in their mode of expression. Some would evidently view National Service Corpsmen as alien invaders.

It should be pointed out that the program is permissive—states may or may not apply for Corpsmen at their own option. Areas of availability as stated in S. 1321 as introduced are "for work with persons in institutions for the mentally ill and mentally retarded and during their return to normal living; in meeting the health and education needs of migratory workers and their families, Indians living on and off reservations and residents of depressed areas and rural and urban slums; in care and rehabilitation of the elderly, the disabled, the delinquent young and dependent children; in improving standards of educational opportunity; and in other projects directed toward critical human needs."

The purpose of the bill is to "strengthen community service programs in the United States." The preamble continues:

> "In the United States there remain critical human needs in this time of general prosperity. In this Nation of great human resources, many more of our citizens should be encouraged to serve in their local communities to help meet these needs.
>
> "The purposes of this act are to open new opportunities for full time service working with those Americans in greatest need; to illuminate those needs so as to expand the attack on deprivation in the United States; to motivate many more citizens to volunteer their services in their own communities, thus encouraging communities to help themselves; and to inspire more people to choose professions that serve their fellow citizens."

Can we not set aside jurisdictional disputes and concern ourselves with the nobler and more urgent duties of citizenship? Can we not direct our efforts toward "the critical human needs of our countrymen?" Can we not accept the full burden of elevating the dignity of this nation? Can we not bring our citizens and especially our young people to the awareness that misery and bitter privation exist in this country and that public morality requires a commitment by all of us toward their alleviation?

S. 1321 is not the only way to do these things, but it is a way. A way that is available to us now.

David J. Vail, M.D.
Medical Director

"There Should Be More Of You..."

Patients Evaluate Volunteers, Affirm Value of Program

"There is no book, paper, magazine or letter that can put the true facts to the people as well as words direct from the mouth of one who knows the real need here."

That statement was made by a mentally ill patient in regard to the Volunteer program in his hospital. It is an excerpt from one of hundreds of letters written recently by Minnesota patients in response to the questions, "How do you feel about the Volunteer program in your hospital?" and, "Why do you feel this way?"

If anyone doubts that the 5,000 Minnesota Volunteers accomplish their task—which is" to bring the community into the hospital," so that the patients may retain or restore their sense of involvement with other people—these letters will bolster his faith. Many of the statements have the sting and resonance of poetry.

"Myself I know that sometimes on the week ends I just travel the corridors to see the new faces."

If that statement is not enough to evoke in a reader all the porcelain loneliness of institutional life, there is this one, written by an old-timer who remembers the period, prior to 1949, when there were no Volunteers:

"A lot of us that never get to go home or get company, sometimes would cry or get lonesome, years back."

Most of the statements, however, express happiness rather than pathos. This one could almost serve as the sunny first line of an Elizabethan lyric:

"I think a time in singing is a happy time."

The same spontaneous, simple quality gives many other statements an odd and touching elegance:

"They cheer my time."

"They add variety to my time of day."

"They are good in things." 'They're a happy lot of people."

In addition to these simple expressions of feeling, many statements made by the patients indicate that the Volunteers succeed *in* keeping patients aware of social relationships, of the complex ways people need and help each other. To a person who has lost the ability to control or predict his behavior, there is a kind of wonder involved in seeing others adhering to a schedule:

"I don't see them failing to do their duty each day and hour."

"They never miss coming."

"I like them because they are always the same."

To a person who is involved in his own troubles to the exclusion of all other things, and who has almost lost the instinctive interest in the objective world which healthy persons take for granted the spectacle of generosity and altruism seems to have a very special poign-ance:

"The greatest gift that can be given is to make someone feel that your services to him were given free."

"I have come to see that by helping others we find it's easier to understand ourselves."

"I think they are doing a fine job every day in every way, each one doing each their work without any pay."

"They make us forget ourselves and our troubles." And this rare bit of wisdom:

"I like them because I've been kind to them." (con't, page 3)

Professional Standards For Volunteer Coordinators

The increasing importance of Volunteer services in the mental health program, and the emergence of the role of Volunteer Services Coordinator as a separate profession were recognized at a conference held at Washington, D.C., August 12-14.

The aim of the conference was to define professional standards and to begin development of a training program for Volunteer Services Coordinators. In the first part of the program, the thirteen participants discussed the Volunteer program from the following aspects: job specifications, recruitment, training, and retention; administrative structure of Volunteer programs; the place of Volunteers in state and national programs; the responsibilities of state-wide volunteer coordinators; staff and line functions of Volunteer programs; relationship between professionals and Volunteers in community programs; and the function and value of Volunteer programs from the point of view of the psychiatrist.

The second part of the conference consisted of discussion of specific means for establishing a training curriculum which would develop standards for the new profession.

The conference was co-sponsored by the American Assoc. of Volunteer Services Coordinators and the American Psychiatric Association, with the financial assistance of the NIMH.

Mrs. Miriam Karlins, President of the AAVSC, and head of the Public Information and Volunteer Section of the Division of Medical Services, Minnesota Department of Public Welfare, was chairman of the meeting.

Names in the News

Arthur S. Funke, Ph.D. Head of the Mental Health Study and Planning Section, Division of Medical Services, Department of Public Welfare, will present a paper explaining the theory and progress of the Minnesota planning program at the Conference of the American Psychological Association in Philadelphia, August 30.

Three articles dealing with the Minnesota mental health program appear in the August issue of *Mental Hospitals:*

Ed Schnettler, M.S.W., and *John P. McNamara,* M.D., "Central Minnesota Mental Health Center: A Clinic Designed to Serve Total Community Needs."

Ivan W. Sletten, M.D., and *Howard Bennett,* B.A., "A Mixed Cottage for Long-Term Patients."

William D. Leipold, M.D., and *Marilyn Wilson,* B.S., "Are We Communicating?"

Patients Evaluate Volunteers

Quite dearly, the result for the patient of mingling with the Volunteers is a feeling of kinship, of being at home with a social group:

"We seem to get along better with this kind of people."

Not all statements are cheery, however, or even approving:

"I don't see them—I never talk to them, I been in institutions half my life—like to get out. They don't bother me—they can come in. I got my own way of explaining things to them."

Barriers have been built in the patient, either by organic disorder or by crippling experience, which are not easily removed. If the Volunteers' work were easy it would not be as valuable is it is.

"As for the reason I don't like the volunteers, it's because most of them seem either afraid of the patients (as though we were related to sea lions and dragons), or a bit too interested to be genuine. There are some exceptions, as in all cases. There are some who are genuinely interested and humane, who really want to help us in heart-warming ways, but even among these there are a *few* who just do not know how to go about helping a mentally retarded or epileptic patient. It's those *few* I feel sorry for."

Some patients seem sullen, apparently un-reachable:

"I don't think much of them, because it's crowded enough during the daytime."

"I don't worry about them. I never ask them to do anything."

Such statements should rarely be taken at face value, of course. The patient's distrust of others is precisely what must be broken down, since more often than not it is simply a reflection of the patient's distrust of himself. The combination of desire-to-trust and fear-to-trust is shown clearly in one girl's wavering remarks:

"I don't like them so good. And furthermore I'm glad I haven't got one. And furthermore, they wouldn't like me if they had me. I like them, but I don't like them to stare at me, I like Mrs. S ..... (a volunteer) cause she's nice to me. At least she doesn't stare at me. Mrs. S is just like a mother. When she sees I'm blue she comes to cheer me up. I'm glad I haven't got one, because I don't like them. They wouldn't like me, because I've never had one. I think it would be better if you were my volunteer, because you're just like a mother."

But most patients have no doubt about the gratitude they feel for the companionship of volunteers. They express it with a force which is a guarantee of its sincerity:

"I like to see them when they call, don't you?"

"They make us feel happy and loved."

"Because they are all OK."

"They should come more often."

"All I have got to say is there should be more of you if it can be arranged."

One patient, whom we shall call James McCarthy, put his feelings in the form of a public proclamation, or a sworn deposition. Despite the pomposity, the vagueness, and the bad grammar, who could doubt its sincerity?

"I, James McCarthy, a ward of this institution, feel very thankful to those organizations of the outside who take such wonderful interest in us patients here. And its a joy to our hearts to know some one cares for you, as our Lord will reward people like that I'm sure.

"Because it's stimulation to the minds of them who understand their everyday living. Course there are many who don't heed what it's all about. But there has to be excuses. So this volunteer work which is being done for us here is well appreciated by all, as we who are able should help others as our Lords command. So I'm sure it's a great help to a lot of patients here when they can talk to those outsiders and receive little gifts as tokens of love.

Yours,

James McCarthy"

The Therapeutic Use of The Self

A Credo For Volunteers

The skills involved in the alleviation of human misery are in their essence not technical but simply human.

It is at this point that the significance of the volunteer movement becomes clear. The capacity for personal healing—"the therapeutic use of the self"—is not the property of any professional body, the sacred mystery of any caballa. It does not require an academic degree. It can and should be perceived, assayed, developed and disciplined: here the professions have their vital role. There is craftsmanship involved. But the capacity to assist another person in his effort to overcome despair, the capacity to advance the human condition is an existential force that each man bears within him, whether he chooses to affirm or deny it, use it or trifle it away.

—From "A Decade of Volunteer Services 1950-1962; History and Social Signifi-

cance" by Dr. D. J. Vail

Rochester Volunteer Makes "Sound" Contribution Coordinates "Services For Deaf Program

One Rochester patient, hospitalized for 10 years, is now at home with his family.

Four others have returned to normal lives after shorter periods in the hospital.

Altogether, 16 patients have significantly improved their chances for complete living as a result of the "Services for the Deaf' program conducted at Rochester State Hospital by a Volunteer, Mrs. Florence Barker.

The program began on May 15, 1961, as a specific service within the hospital's department of social work, headed by Mr. John Isaacson. The aim of the program was, first, to identify those "forgotten patients" who were not only mentally ill but also deaf, and, second, by alleviating their deafness through surgery or hearing aids, to facilitate treatment of their mental disorders.

The problem was not lack of facilities. Agencies existed in the community, hospital, and welfare department to diagnose, prescribe and provide after-care for the deaf. But no one had ever determined the exact number of deaf mental patients at Rochester; no one had worked out how to route the patient through appropriate medical and otological services; how to overcome negative attitudes on the part of patient: and their families; to arrange for financing hearing aids, where needed; to assist patients in making maximum use of hearing aids or other therapies; to follow up patients by personal visit and by referral to such agencies as the Public Health Visiting Nurses Association; and finally, to systematically record and evaluate the progress of individual patients and the over-all operation of the program.

No one questioned the assumption that much could be done for certain patients if all available psychiatric, medical and rehabilitative functions could be coordinated. The immediate and only difficulty was lack of staff, which always means two things: lack of money, and lack of a person with the skills necessary Co do the job.

This is where the Volunteer Services came on the scene, in the person of Mrs. Connie Schoen, Volunteer Services Coordinator, who recommended Mrs. Barker. As a Volunteer, Mrs. Barker was willing to work without salary.

As a Volunteer with considerable previous experience on the board of several community agencies, she had the necessary skills: she knew the problems of the handicapped, what could be done to help them, and who she had to see to get it done.

In short, her experience, dedication and energy were all that was needed to convert a pious hope into a fact.

Since 1961, the program has registered 114 patients. Fifty-seven of these have been unable to benefit from testing and treatment. Of the remaining 16 are now successfully using hearing aids, and 26 are scheduled for future surgery and therapy.

Some results have been spectacular, as in the cases already mentioned. But even where there have been few immediate psychiatric benefits, there have been obvious "social" benefits. Now able to hear, patients who once gave an impression of being helplessly removed from reality are now able to relate more easily to the life around them. Sometimes they relate almost too well, like the gentleman who turns off his hearing aid in the dining room because he just can't stand the unaccustomed noise! But now at least the choice is his; the sounds of reality—and hence to some degree his own mental soundness—are now more easily at his control.

At present the hospital is applying to the National Institute of Mental Health for a grant to continue the program and to extend it to other hospitals. Mrs. Barker, who is preparing an article on the program to be submitted soon for publication, has promised to remain at her crucial job. No one has much doubt about the future of this long-neglected service, it's here to stay, a model of how much can be accomplished by cooperation between professionals and Volunteers—a "sound" contribution to mental health.

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St. Paul 1, Minnesota
Division of Medical Services
Department of Public Welfare

Mental Health Newsletter

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Editorially Speaking

THE PROBLEM OF DEHUMANIZATION . . .

On September 13, 1963, at the annual Institutional Assembly, staff members of Minnesota's institutions for the mentally retarded and mentally ill were asked to address them to the Problem of Dehumanization.

It is not as if we had just now discovered dehumanization and are finally getting around to doing something about it. We have been concerned about it and working on it for years, though the concept has possibly been outside of our conscious awareness. The 1949 Minnesota Mental Health Act, for example, concerns itself very specifically and at some length with dehumanization, in sharp contrast with the relative paucity and vagueness of other goal statements in mental health laws.

What made our meeting of September 13 a milestone was the fact of formally recognizing dehumanization and deliberately drawing attention to it as a problem of official concern to the Department of Public Welfare. The department and its subsidiary branches, particularly its mental institutions, must address itself to the solution of this problem. In doing this it must use all the resources at its disposal, organized in proportion to the magnitude and urgency of other problems in the context of total accountability.

We have defined dehumanization as the divestment of human qualities and functions, and alternatively as the process of becoming, and the condition of being, less than a man. One cannot explore the concept of "dehumanize" without pausing, if ever so briefly, to examine what is meant by "human". What seems vital here are these four elements: self-awareness, dignity, one's sense of his own value, and the capacity for personal growth. Take for example growth: the possibility that this year one may be bigger in wisdom, in capacity to love, and in sense of fulfillment than was the case a year ago. If one contemplates the opposite, he may then get a glimmering of dehumanization.

Dehumanization can be found in many places: not only in mental institutions, but also in general hospitals, prisons, labor camps, Indian reservations, group care facilities, boarding schools, etc. It can indeed occur in a family and be produced by spouse, parents, even siblings. It is more likely to occur, however, where people are maintained by strangers in some dependent situation. A welfare worker finding a foster home for a dependent and neglected child should be concerned with dehumanization, as should his colleague placing an old person in a nursing home. The proposed National Service Corps, in effect, addresses itself to this problem—its passage might be more certain and its ultimate usefulness enhanced if that fact were recognized.

Fascinating puzzles emerge. Does the loss of hearing or vision have a dehumanizing effect? The loss of a limb? A fortunately rare operation removes the whole lower half of the body—at what point in the loss of physical integrity does one become less than a man? These examples may or may not be accepted as instances of dehumanization. But what about the loss of memory, intelligence, will or self-control? Here one wonders. Until a relatively few years ago it appeared that society had decided that the "mental patient" was already less than human before entering the asylum. This was why he had to be "put away" in the first place and why the shocking conditions of those times could be countenanced by decent, honest people. To what extent has this really changed? At what point "mental illness" (whatever that is) leaves off and the institution takes over the dehumanizing process is moot. That the institution can and does dehumanize there can be no doubt. Some of the best statements on dehumanization come from the patients themselves. Moreover, we have found the ideas of Erving Goffman especially useful in understanding how dehumanization takes place in what he terms total institutions. Elsewhere in these pages is shown the discussion guide, based on Goffman's work, which was used at the September 13 meeting, together with a summary of Goffman's concepts. The checklist will be used in discussions during the ensuing months throughout our institutions, at all levels.

Another important point emerged at our conference, the effect of dehumanization among staff. Just as we can gradually lose our political liberty if we do not actively serve the cause of justice, so if we tolerate dehumanization, condone it, foster it, and go to sleep next to it, to this extent we lose our own humanity. I am my brother's keeper, and if you stab him it is I who must bleed.

David J. Vail, M.D.
Director
Division of Medical Services

Individual Rehabilitation Programs Stressed At Anoka Conference

The importance of designing rehabilitation programs for the individual patient rather than for large groups was discussed this month at the 7th Annual Rehabilitation Therapies and Education Conference at Anoka State Hospital.

Mr. H. Dwyer Dundon, director of graduate program and associate professor of psychiatric occupational therapy at the University of Nebraska, emphasized in his keynote address that the therapist must be an integral member of the treatment staff, and must aim all his activities with patients at therapy rather than mere recreation.

During the two-day conference, supervisors, teachers, and therapists from all of Minnesota's hospitals and schools for the mentally ill and mentally retarded analyzed hypothetical individual cases, work out specific diagnoses and programs of treatment and rehabilitation.

Glen Lake And Hastings Hospitals Receive National Accreditation

The most gratifying event of recent times for the Medical Services Division has been the approval, this September, of Hastings State Hospital and Glen Lake Sanatorium for accreditation by the Joint Commission on Accreditation of Hospitals.

Accreditation is for the standard three-year period beginning with the date of the inspection, August 2, 1963, This is the basic approval given in hospital work, and is recognized as a national standard. It is the basic step to other kinds of accreditation and approval, such as nursing school affiliations and residency training in psychiatry.

Other accredited Minnesota mental hospitals are Rochester and Anoka.

One element of significance is that Hastings is the first state mental institution in the country administered by a non-medical administrator to be accredited by the JCAH. Thus the Hastings instance sets a precedent which should have many implications for future developments in the administration of mental hospitals in Minnesota.

NEW FACES

AH-GWAH-CHING

Eileen McAndrews RN II—5-29-63
Frances Reed—RN II—9-11-43
Sandra Sawyer—Soc. Wkr. I—8-26-63

ANOKA

Marion Aarbsy—Hosp. Wkr. 8-12-63
Ruth Anderrg—Hosp. Soc. Wkr.—9-4-63
Charles Bernett—Hosp. Soc. Wkr.—6-17-63
Wilbur Bryant—Staff Physic—7-1-63
Robt. Burton—Staff Physic.—7-24-63
John Docherty—Med. Dir.—5-16-63
Mary Eichhorn—Chief Psychia.—8-7-63
Marilyn Elfstrand—Sur. Nurse II—7-17-63
Alden Halloran—Hosp. Soc. Wkr.—6-17-63
Mary S. Humphry—Psychol. II—7-24-63
Robt. Lewis-Vol. Services Coord.—6-10-63
Marion Lucero—RN II—4-17-63
Barbara Luoma—Occ. Therapist I—7-1-63
Carolyn Nelson—RN II—7-10-63
Richard Subro—Pharmacist—7-3-63
Norma Thompson—RN II—5-15-63
Paul Wick—Sr. Chaplain—8-7-63

BRAINERD

Helen Butterfield—RN II—8-14-63
Patricia Willette—RN II—7-24-63

CAMBRIDGE

Laura Barron—RN II—4-3-63
Janice Bouma-Spec. Sch. Couns. I-8-7-63
Shirley Carlson—RN II—9-4-63
Ellen Farmer—RN III—3-21-63
Brian Goodno—Pat. Act. Asst. I—4-24-63
Robt. Hanson—Spec. Sch. Couns. 1—8-7-63
Robt. Hockaday—Spec. Sch. Couns. 1-8-8-63
Ruth Larkln—RN II—9-4-63
Thos. Lindquist-Spec. Sch. Couns. I - 8-8-63
Catherine Lyons-Phy. Therp. III—8-1-63
Arvid Olson-Spec. Sch. Couns. I—8-7-63
C.W Peterson Spec. Sch. Couns. I-8-7-63
Fred Scott—Spec Sch. Couns. I—8-7-63
W. Rennaker-Spec. Sch. Couns. I—8-7-63

FARIBAULT

Frank Amedeo—Pyshol. II—9-3-63
Marie Anderson—Spec. Tchn.—8-29-63
Vivian Bisphan—RN II—6-20-63
Dean T. Clarke—Staff Physic.—8-1-63
Mary Cody—Pat. Act. Asst. I—8-15-63
Lorraine Dudley—RN II—4-29-63
M. Elaine Hoem-Pat. Act.- Ldr. I—7-8-63
Chrisanne Hokanson-Spec. Teacher-9-2-63
Mary Kalow—RN II—5-20-63
Jean Larson—Spec. Tchr.—-8-29-63
Roger Lowe—Pat. Act. Ldr. I—8-5-63
Jeraldene Mondloch—RN II—9-4-63
James Potter—Spec. Tchr.—8-29-63
Dennis Wampler—Spec. Tchr.—8-29-63

FERGUS FAILS

Thos. Coleman—Chaplain—7-1-63
Vera Holstaad-Pat. Act. Asst. II—4-3-63
Norman Midthun-Hosp. Soc. Wkr.—7-1-63
LaVerne Novak-Hosp. Soc. Wkr.—7-1-63
Theo. Olson—Pat. Act. Asst. II—4-3-63
Gordon Persinger—Psychol. I—6-10-63
Barbara Sanborn—Pat. Act. Ldr. I—6-3-63
Robt. Shelton—Pat. Act. Asst. II—4-3-63
Brian Soland—Soc. Wkr. I—9-4-63
Sylvia Solberg-Pat, Act. Asst. II—4--3-63
Shirley Swiontek-Pat. Act. Asst. II-4-3-63

GLEN LAKE

Lewis McGonagis—Pharmacist—6-14-63
Jessie Strauss—Pat. Act. Ldr. II—5-6-63

HASTINGS

Faruk Abbuzzaahab-Chief of Serv.-6-26-63
Anita Folch—0cc. Therp. II—8-19-63
Ostrude Holte-Hosp. Soc. Wkr.—9-4-63
Unae Kilgas—RN IV—7-11-63
Margaret Matsch—RN III—7-24-63
Marguetta Origa—RN II—8-6-63

LINO LAKES

Mildred Byrum—Psychol. II—6-16-63
Francis Cahill—RN II—7-31-63
Donald Ehrich—Hosp. Soc. Wkr.—6-17-63
Arthur Gallesa—Psychol. III—4-1-63
Richard Kempler-Pat. Act. Ldr. II—7-8-63
Darlene Marvy-Child Care Couns.—7-29-63
Ruth Steiner—Spec. Tchr.—7-1-63

MOOSE LAKE

Audrey Anderson—RN II—6-3-63
Joyce Hultberg—RN II—9-18-63

OWATONNA

B. Amundson-Spec. Sch. Couns. I—9-18-63
Julia Boart-Spec. Sch. Couns. I—8-18-63
Dewey Jackson—Spec. Tchr.—9-1-63
Harold Smith-Spec. Sch. Couns. I—9-16-63

ROCHESTER

Joyce Bickford-Chief of Serv—5-29-63
Amy Christensen—RN II—4-3-63
Donna Christensen—RN II—9-4-63
Robt. Collis—Staff Physic—7-12-63
Leola Furman—Soc. Wkr. I—9-9-63
Phyllis Larson—RN II—9-4-63
Mary Martin—Social Wkr. I—5-15-63
Mardalle Schwenke—RN II—8-7-63
Roger Van Buren—Soc. Wkr I—4-3-63
Janet Vielhaber-Phy, Therapist I-9-4-63

ST. PETER

Gladys Aason—Med. Tech. I—5-20-63
Shirley Frey—Pat. Act. Asst. II—4-17-63
Eugene Grabow—Soc. Wkr. I—8-16-63
John W. Gridley-Sr. Staff Physic.—5-6-63
Burton Grimes—Med. Dir.—7-1-63
Wm. C. Lightburn—Hosp. Admin.—7-1-63

WILLMAR

Mary Aldrich—RN V—4-3-63
Margaret Baurmgartner—RN II—8-21 -63
Charles Bloom—Physician—7-1-63
Alfredo Sadi Prada-Staff Physic.-5-13-63
Rosemary Trihey—Soc. Wkr. 1—9-16-63
Jean Uyeno—Soc. Wkr. I—4-8-63

Mental Health Newsletter

DEPARTMENT OF PUBLIC WELFARE

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Editorially Speaking

THE FUTURE OF THE MENTAL HOSPITAL

In psychiatric and mental health circles on both sides of the Atlantic an important emerging center of interest is the problem of the future of the mental hospital. It is not an easy subject for rational consideration. The determinants are not clear. Whatever may be put forward in the way of logical argument can be found to have emotional overtones based on subtle combinations of crusading zeal and

One waggish observer from without, as it were, with no prior commitments regarding the mental hospital as a social institution, has concluded that two kinds of persons exist in the field, the Hospital Savers and the Hospital Busters. This is oversimplified but useful.

The Hospital Savers contend rightfully, we believe, that the mental hospital has and will continue to have a legitimate and honorable position in the total concatenation of mental health facilities. Be there ever so many mental health education programs, community mental health centers, psychiatric beds in general hospitals, and advanced private or even government insurance programs, there is short of some fantastic biochemical breakthrough no visible evidence that the problem of chronicity can be eliminated. To be sure, enlightened programming has substantially attacked the so-called "hard-core" and it is possible in theory to at least cut short the continuing accretion of hard core cases. In other words, suitable programming will hold the hard core at its present level while no new patients are lost into it and meanwhile the present group gets older and eventually disappears. But how many mental hospitals in this country are adequately staffed to do this job? And for that matter where does programming of sufficient imagination and vigor exist for this to happen? Is the concept based on real possibility or just wishes? Will it go against the public will? Will it by eliminating the sanctuary function of mental hospitals do a disservice to the patient? These are serious and deep questions. Unfortunately Hospital Savers may weaken their position by seeming to hold forth the innate dignity, beauty and goodness of the Mental Hospital. The cynic can discern heavy investments and large loyal establishments at stake. In Minnesota parlance one can see evidence of the external goals of the organization, defined by society, being overshadowed by concern for the internal goals. This can lead to effort to maintain the organization for its own sake, to the further dehumanization of the patient.

The Hospital Busters, on the other hand, hold that the mental hospital can and must be eliminated. The validity of their argument rests on the fact that treatment close to one's family, job, and community are more to be desired than removal from them; that institutional life with its leaching effect is to be avoided. If it can be avoided, that is (and it has been pointed out that so far the only really indispensable instruments in the mental health concatenation is the mental hospital.) And other things being equal (and they never are). In its more irrational reaches the Hospital Buster position seems to rest on the notion that not only does the mental hospital epitomize indignity, ugliness and evil but further that it must and shall always be thus.

The positions have been simplified and made somewhat absurd for purpose of emphasis. But read your reports and depositions and you will see them. For Hospital Saviorhood note the official transactions of the A.P.A. Mental Hospital Institutes. For the opposite, testimony in favor of the new federal community mental health programs.

The truth and the right way must be somewhere in between. The mental hospital which concentrates its attack on the Problem of Dehumanization cannot go too far wrong. Shifts in orientation may be needed, for example the mental hospital in relation to a certain level (not kind) of disability and the mental hospital as an educational institution.

Dialogue is essential here, hopefully free of irrationalism. In any event, whether at the level of thought or action, let there be less posturing and more producing. Bernard Baruch: "Do an honest day's work and the country will take care of itself," An honest day's work includes, we believe, some period of contemplation. But whatever we do must be honest, not based on prejudice or self-perpetuation. It must be directed to, as it is caused by, concern for the public good.

David J. Vail, M. D.
Director, Medical Services Division

"The ties that bound us must be cut..."

Patient Analyzes Dependency On Hospital

EDITORS NOTE: As part of a continuing discussion of the problem of dehumanization, patients and staff in all Minnesota mental hospitals and schools are exchanging opinions regarding its sources and solutions.
The following letter was submitted by Don Peterson, a Patient at Fergus Falls State Hospital.

Certainly one of the biggest and most puzzling problems the staff faces is what to do about the patient who depends too heavily upon the hospital. Likewise, when should the patient be allowed to be dependent, and when should he be prodded a little, or a lot. In this line it might be well to consider a few reasons why some of us come to be too dependent upon the hospital.

Speaking from personal experience, I feel some of us may have been too dependent upon our parents in childhood. We may have been victims of over-protectiveness, and not allowed to chance too many things. We may not have been given responsibility, or not encouraged to accept it. Perhaps we were criticized; felt rejected, and developed feelings of inferiority. So we accepted the protection and security our home provided. When the tune came that we had to leave our parents and nest, we were ill-prepared to make our own decisions and to accept the responsibilities of adult life. We developed problems and symptoms which, maybe sooner, maybe later, required our hospitalization, and here we found a nice warm nest again. It was easy to depend upon the hospital for all our needs and it was easy for the hospital to allow us to be dependent, physically, socially, and psychologically. Before we really knew it we had drifted into a pattern of dependency and complacency, we had our jobs to keep us busy, but not too busy. Somebody else made the decisions and did the worrying. When we were threatened we had Mom and Dad, in the form of hospital employees, and also drugs, to ease our minds. We were comfortable, so why change? Why risk the outside world again? So the policy of custodial care developed.

But now the hospital, and society, expects more from us. We are expected to become useful citizens, and to contribute as much as we are able to, to society. The hospital and staff will help us all they can to achieve this goal. But the larger share of the burden rests upon us as patients. When we have a physical ailment or complaint the doctor can prescribe pills or medicine to help the body cure itself. Maybe hospitalization is necessary, but we do not intend to stay in the hospital the rest of our days. Mental illness is different however, in that the medicine and doctor can do only so much, and then the patient must take the responsibility of recognizing his own problems and working towards solving them. This takes conscious effort.

What are some of the steps we can take to help prevent drifting into this state of dependency, or of working our way out of it if we are already caught in it? Perhaps the most important one is to recognize when we need to be dependent and when we do not. I am sure we are all aware of the newer programs in which the patent is encouraged to accept more individual responsibility. However, some patients seek to be too independent, which is not the ideal situation either. So we must walk somewhat of a tightrope or do a balancing act. Then too, we must realize that we are here for treatment, and work toward that end. We must participate in the activities provided for us; activities designed to help us renew our interest in life outside the hospital, and in life itself. We must learn to overcome our fears that may have brought us here, gain new confidence and self-reliance in our own abilities, and learn to accept and live with our short-comings that cannot be changed. Now to do all these things would require many columns to discuss only superficially. Perhaps it would suffice to suggest that we allow ourselves to be put into positions of responsibility, however small they may be, learn that they are not so bad, and receive courage from our successes. Soon we may be able to accept more responsible tasks, or even to seek them ourselves. Experience will help to build our confidence. To do these things is not easy. It will cause trials and certainly worry and suffering, mental and perhaps even physical anguish. But the end results are well worth it

It might be well to ask if the feeling of dependency pertains only to the patients, or does it extend to the staff as well? Might it be that sometimes employees become so comfortable in their own jobs, that they do not motivate the patients as they should? Might it be easier to keep patients rather calm, than to undertake the responsibilities that a little prodding would require? I once heard it said that the duties of a minister were not only to comfort the disturbed, but also to disturb the comfortable. Might not this also apply to our hospital?

In conclusion, what should we do when we are discharged, so we will no longer feel dependent upon the hospital, and thus be tempted to return when life gets a little rough? We should no longer look upon the hospital as a home. In fact, it might be well to get as far away as possible, emotionally at least, if not physically. We must remember there are places where we can receive counseling and guidance if we need it, and still continue our life outside. We must make new friends outside, and not come back to visit friends still here. To do the latter would maintain too strong a bond to the hospital. The ties that have bound us to the hospital must be cut the same as were, or must be, the ties that bound us to our home and parents

ANOKA
Marion Aarsby—Social Wkr.—10-14-63
Mary Rowley—Occ. Therapist I—9-30-63
BRAINERD
Jacqueline Beoulieu—RN III—10-2-63
Jo Ann Johnson—Spec. Tchr.—10-1-63
Veronica Tentinger—RN II—10-2-63
Irene Yenish—RN II—10-1-63
CAMBRIDGE
Jean Parsons-Spec. Sch. Couns. I-10-11 -63
FARIBAULT
Patricia Davis—Spec. Tchr.—9-3-63
Geraldine Jacobson—RN II—9-16-63
Clara McKenzie—Spec. Tchr.—9-23-63
Judith Lowe—Spec. Tchr.—9-4-63
Elmer Ruchling—Spec. Tchr.—10-2-63
Georgine Svatos—RN II—9-16-63
FERGUS FALLS
Dale Eichelberger-Staff Physician-9-18-63
Dorthy Sperling—Psychol. I—9-18-63
Marguetia Origer—RN II—9-17-63
HASTINGS
Michael Bowler—Soc. Wkr.—10-15-63
Cherry Cedarleaf—Staff Phytician—9-23-63
LINO LAKES
N. C. Adams—Child Care Couns.-I0-14-63
Lloyd Arnovich-Child Care Couns.-I0-2-63
Roger Bevis-Child Care Couns.—9-30-63
Eunice Davis—Chief of Service—10-2-63
Edith Kopieckl—RN II—10-1-43
Donald Nonson-Child Care Couns.-10-14-63
MOOSE LAKE
Fernando Lopez-Sr. Staff Phyiscian-10-14-63
OWATONNA
Wm. J. Guse-Spec. Sch. Couns. I—10-2-63
Ethel Ochs—Spec. Sch. Couns. I—9-18-63
ROCHESTER
Kathleen Dening—RN II—10-2-63
Milton Fisher—Asst. Sup.—10-2-63
Doris Martin—Surg. Nurse II—9-18-63
Betty Visker—RN II—9-18-63
ST. PETER
Dona Mae Macias—RN III—10-7-63
Judy Rodning—Soc Wkr. I—10-2-63
Janice Schultz—Soc. Wkr. I—10-14-63
WILLMAR

Names in the News

Arthur Funke, PhD., Director of the Minnesota Mental Health Study and Planning Program, reported on Minnesota planning activities at the annual meeting or mental health and mental hospital authorities from Region VI of Public Health Service on October 29-30 at Rochester.

Harold W, Peterson, administrator of the Brainerd State School and Hospital: elected president of Minnesota Hospital association, which represents 101 hospitals in this state.

Dr. James T. Laird, psychologist at the Northern Pines Mental Health Center, and author of the Minnesota Percepto-Diagnostic test: recently presented topics on perception at the Minnesota Psychological convention and at the American Psychological Convention hi Philadelphia.

Dr. Dale Eichelberger: newly appointed staff physician at Fergus Falls State Hospital; medical residency at University of Minnesota Hospitals, followed by service with U.S. Navy.

Milton Fisher: new assistant superintendent at Rochester State Hospital; master's degree in public administration from Cornell University; formerly director of rehabilitation at Utah State Hospital.

Miss Helaine Todd. Volunteer Specialist with the Bureau of Family Services of the United States Department of Health, Education and Welfare: will visit central office the week of November 3 to observe the Minnesota program of Volunteer services.

CMH Center Lines

Northern Pines MHC Little Falls—sponsored a seminar entitled "Individuality of the Aging" October 10. Jeanette L. Baker, M.D., discussed "The Medical Aspects", Mildred Moe, R.N., "Nursing Home Care", and Rev. Russell V. Ewald, "Spiritual Needs." The Center is now planning a workshop on "Family Therapy and Counseling" for professional personnel in its four-county area using two films circulated by the Family Institute in New York.

Central Minnesota MHC, St. Cloud—Dr. Donald C. Carter was appointed Clinical Director replacing Dr. John P. McNamara, who is now in full time private practice in the St. Cloud area. Dr. C. S. Donaldson was recently elected chairman of the center's mental health board replacing Mr. E. A. Zapp, who continues to serve on the board

Western MHC, Marshall—Dr. Harper Willis, psychiatrist, passed his October 15 examination in Chicago and has now been certified in psychiatry by the American Board of Psychiatry and Neurology.

The center held its fourth annual workshop on religion and mental health during September featuring Dr. C. F. Midelfort of LaCrosse, Wisconsin, as speaker. A standing-room-only audience attended the center's open house on September 29 to see the new office space, an art show loaned from the Walker Institute, and a Russian film called "A Summer to Remember."

Southern Minnesota MHC Albert Lea—During September, Dr. Arnold, psychiatrist, and Dr. Sam Selzer, psychologist, helped present a program to 55 police and sheriff's officers on the best means of handling emergencies involving mentally ill people.

South Central MHC Owatonna—Sunday, Nov. 3, has been set as the date of an open house at the remodeled and enlarged center. Since opening in 1959 the center has had 1,500 cases. Two more psychologists will be hired in the near future to serve most of the school districts in Steele, Dodge, Rice, and Waseca counties.

Range MHC, Hibbing—The annual dinner meeting was held on October 17. Dr. Thomas McPartland, director of research for the Kansas City Mental Health Authority, spoke on "The Community as a Therapeutic Device."

Duluth MHC Duluth—Two new staff members are William Van Druten, staff psychiatrist, M.D. from Stanford University, residency with U.S. Air Force; Charles Van Buskirk, staff psychologist, Ph.D. Chicago University, three years with the University of Iowa counseling service.

Also at Duluth, Mrs. Donna Kumm Green, psychological social worker, has recently initiated an adolescent discussion group for girls.

Hospital Echoes.. .

The barred gates of the Minnesota Security Hospital at St. Peter are being open to female nurses for the first time in the unit's 56-year history. Installed as head nurse: Mrs. Donna Macias, whose duties will include supervision of the male attendant guards.

Mrs. Alvira Hiltz, nurse consultant for DPW, was special guest at a one-day hospital orientation program for public health nurses at Rochester SH this month. Participating in the program were Dr. Robert Rynearson, coordinator of the treatment program; Dr. John Hawkinson, head of the department of clinical psychology; and nursing supervisors, head nurses, and instructors.

At Hastings SH, 25 MaCalester College psychology students have begun a one-to-one patient visiting program; each student will make a weekly visit for the next two months. Carleton and St. Olaf College students also have a program at Hastings which involves participation in dances, open houses, and ward visits.

Patients at Moose Lake State Hospital turned the tables and entertained the Volunteers at a recent appreciation dinner. Mrs. Sally Luther, Administrative Assistant to the Governor, spoke to the group about the state-wide volunteer program.

In cooperation with the Minnesota Association for Retarded Children, Minnesota's institutions for the mentally retarded will hold open houses on November 3 in observance of Retarded Children's Month. Programs involving public tours and talks by institution staff and MARC personnel will be held at the State Schools and Hospitals at Faribault, Cambridge and Brainerd, and at the Owatonna State School, Lake Owasso Children's Home and Shakopee Home for Children.

The Association of Mental Hospital Chaplains, Upper Midwest Division, held its second annual meeting at the Rochester State Hospital October 28-29. Aim of the meeting is to acquaint community clergy and seminarians with the problems of the mentally ill and with means of ministering to them under the supervision of an institutional chaplain.

Current Treatment For Mental Retardation Based On Concept of "Continuum of Services"

Treatment programming to meet individual needs is rapidly replacing wholesale hospitalization as an answer to the problems of mental retardates in Minnesota, according to Frances Coakley, Supervisor, Section for Mentally Deficient and Epileptic.

Speaking at a recent meeting of the Minnesota State Volunteer Council, Miss Coakley explained that whereas at one time retardates were cared for in only two places —at home or in State institutions—now there is a "continuum of services" in the community which fills the gap between home and hospital, enabling the retardate to secure help with a minimum of disturbance to his normal way of life.

The continuum (which can be thought of as any straight-edge or ruler) has five significant points, each defined in terms of the type of service it offers and of its distance from the retardate's home, distance here being not only physical but also psychological and legal.

At one end is the home itself. Available here are Homemaker services, Public Health Nurses, public and private welfare agencies, and private physicians.

At the second point are the research, evaluation and out-patient services offered by such agencies as the community mental health centers, the University of Minnesota, State agencies such as the DPW Section of Rehabilitation and Bureau of Psychological Services, and numerous private agencies, such as the Kenny Foundation. Patients using these services continue to live at home, the only difference being that they are in some sense "under a doctor's care" and must visit him from time to time.

At the next point, the patient spends much of each day away from home under the guidance of persons other than his family and friends. Services available here include Day Care Centers for the Retarded, Special Education Classes supervised by the State Department of Education, and sheltered workshops, such as the Opportunity Workshop in Minneapolis.

At the fourth point, the patient lives away from home but usually within easy visiting distance. Services include nursing homes, boarding homes, and Minnesota's 14 Special Group Care Facilities.

At the end of the continuum are the State institutions which, under present policy, are to be reserved for those retardates who require services either too expensive or too complex to be maintained by local communities. The State Schools and Hospitals, for instance, are to be reserved for those who cannot take care of their personal needs because of either severe retardation or multiple handicaps. The State Hospitals now care for many who are not only retarded but also emotionally disturbed.

Miss Coakley pointed out that this "continuum of services" now makes it possible to direct the patient to the kind of resource most appropriate for his needs. It also helps to insure that a patient's condition is accurately evaluated: that handicapped persons of normal intelligence are not mistaken for retardates; that retard-aces are not mistaken for psychotics; or that trainable or educable retardates are not considered to be beyond help. As an example of the importance of accurate evaluation, Miss Coakley cited the 4-County project carried on at Fergus Falls since 1957; of the first 244 evaluated, only 46% were found to be mentally deficient Also, of the 6,500 retardates in State institutions, it is now known that 1,000 do not require the costly complex services of a State institution; they will be moved to community facilities as soon as these are available.

Minnesota's current policy regarding treatment of mental retardation (and mental illness) is "community-centered" rather than "hospital-centered" But one should not conclude that the hospitals are less "important" than they have been. For those who need them, they are indispensable, just as oxygen tents or radiation therapy is sometimes indispensable. In fact the "new" hospitals will present special problems: since patients will be those who are virtually helpless, more staff will be needed to care for them and to do maintenance work now largely relegated to patients. Obviously, if the values of "community-centered psychiatry" are to be realized, we must still have efficient hospitals; for there must be some point on the continuum or services equipped to serve those whose needs are complex.

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St. Paul 1, Minnesota
Division of Medical Services
Department of Public Welfare

Mental Health Newsletter

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Editorially Speaking

John Fitzgerald Kennedy

Some 200 persons from Minnesota's mental institutions were gathered at an Institutional Assembly on Friday, November 22. When the frightful news of President Kennedy's death came, we did not know quite what to do. We decided to stay and finish the meeting, this year's second exercise on the all-important Problem of Dehumanization. In part we were able to

the next days. In part we were responding to habit, relieving our anxiety by doing something familiar and expected.

But our decision to continue was deliberate. It was a small, humble effort at dedication and commemoration on behalf of the President. To us it seemed that this is what he would have wished. For Mr. Kennedy was a friend of the mentally ill and mentally retarded, the underprivileged, the alone and sore beset — all those living in what he called "the dark side of American life." He was also a dedicated public servant: a professional himself, he sought to promote public services as a career, to enrich America by attracting brains and talent into the service of the republic and of her citizens. With his style, his wit, his intelligence, his flair for dialogue and controversy, his immense vitality, and the prestige of his office, he gave dignity and zest to public work. His career in its fulfillment and ultimate end was a total dedication to the nation. Those of us working in our tiny special vineyards of public life can take inspiration from his example, and comfort from his approval. "Let the public service be a proud and lively career."

Let his own words speak to us and to those we serve. These are taken from his comments three short weeks before his death, at the signing of the historic legislation on community mental health and mental retardation centers:

"The nation owes a debt of gratitude to all who have made this legislation possible. It was said, in an earlier age, that the mind of a man is a far country which can neither be approached nor explored. But, today, under present conditions of scientific achievement, it will be possible for a nation as rich in human and material resources as ours to make the remote reaches of the mind accessible. The mentally ill and the mentally retarded need no longer be alien to our affections or beyond the help of our communities.

"... I think that in the years to come those who have been engaged in this enterprise can feel the greatest source of pride and satisfaction and they will recognize that there were not many things that they did during their time in office which had more of a lasting imprint on the welfare and happiness of more people. So, I express all of our thanks to them, and I think it is a good job well done."

We have no space centers to dedicate to John F. Kennedy, no bridges or art institutes. But we have our minds and our bodies, our zeal, our will; we can give these over to what he stood for: a standard of excellent performance, solid accomplishment, and complete commitment to the public good.

David J. Vail, M. D.
Director, Medical Services Division

NIMH Personnel Study Variations In Minnesota CMHC Programs

NIMH personnel responsible for drawing up guidelines for the new Federal legislation dealing with instruction of Community Mental Health Centers visited Minnesota December 12-13 to acquaint themselves with several types of Center programs now in operation here.

As outlined by Bertram S. Brown, M.D., special assistant for the program, the responsibility of his committee is to develop a set of regulations that can make it possible for Centers of all types to be eligible for construction funds.

At the same time, he pointed out; regulations must conform to three basic requirements of the law:

1) To qualify for funds, communities must demonstrate that a comprehensive mental health program exists which provides three essential services: in-patient care, out-patient care, and transitional or day-night hospital care. (Two other services are encouraged but not mandatory: consultative and training programs for other "caretaker" agencies, and 24-hour emergency psychiatric care.)

2) "Reasonable assurance" must be given that a continuum of the above services exists which enables patients to move easily from one facility to another according to their needs. This assurance must come from some individual or group within the community vested with the necessary administrative authority to coordinate the activities of all resources.

3) States must show that their plans for new construction are related to statewide mental health planning and programming, and are endorsed by the mental health authority.

The vigorous growth of Minnesota's CMH Centers has tended to create some problems relative to these regulations, according to Robert Pfeiler, M.D., Director, Community Mental Health Services. He pointed out that some Centers have tended to emphasize certain services rather than others, and that these legitimate differences in philosophy and operational policy complicate the issue of how to determine whether a Center qualifies for federal construction funds.

To illustrate, Dr. Pfeiler pointed out that Centers differ greatly among themselves in the percentage of their time they devote to direct services with individual clients, from a high of 72% to a low of 12-15%, Time spent in consultation with other agencies varies from 85% to 15%.

In-Service Training Needs Noted In Region VI Conference Report

The most urgent current needs for in-service training in Minnesota are in the fields of adolescent and geriatrics treatment according to an omnibus report on in-service training programs prepared by an interdisciplinary committee for presentation at the recent Region VI Conference on In-Service Training Programs in Omaha.

Members of the committee, all of them delegates to the seven-state conference, were William Schofield, Ph.D., University of Minnesota; Alvira Hiltz, Institutions Nursing Consultant; Robert C. Pfeiler, M.D., Assistant Director, Medical Services Division; Arthur S. Funke, Ph.D., Director, Minnesota Mental Health Study and Planning Program; Miriam Karlins, Director, Section of Public Information and Volunteer Services; Gary Hazelhuhn, Welfare Training Supervisor; Ardo Wrobel, Institutions Consultant on Rehabilitation Therapies; John Malban, Administrator, Hastings State Hospital; Donald Muhich, M.D., Program Director, Range Mental Health Center; and Isabel Harris, Ph.D., University of Minnesota.

Aims of the conference were to delineate areas of unmet needs, to explore methods of expansion, to discuss how State mental health agencies, NIMH, and colleges and universities can cooperate in devising more adequate training programs, and to develop a model for a mental health training program.

In-service training programs now operating in Minnesota include psychiatric aid trainee education, mental health training for county welfare staff, registered nurses education, patient activity assistant training program, remotivation training program, in-service training for psychologists and for chaplains, workshop for Community Mental Health Centers, inter-institutional assemblies, and training for Volunteer Services Coordinators.

ANOKA
Wilber Bryant — Staff Physician — 11 -4-63
LaVonne Painter—Staff Physician—11-20-63
Delores Sanchez—Staff Physician—11-6-63

BRAINERD
Beatrice Gunderson — RN II — 10-30 63
Ronald Niemeyer—Pat. Act. Asst. I-11-18-63

CAMBRIDGE
Dorothy Bartlett—Soc. Wkr. I—10-28-63
Raymond Daniels—Soc. Wkr. I—10-28-63

FARIBAULT {deaf}
Dellray Kalina—Spec. Tchr.—9-30-63
Hazel Kramer—RN II—10-18-63
Antusa Santots---Psychologist II — 12-2-63
Hilbert Ruthenbeck—Spec. Tchr. — 11-4-63

FERGUS FALLS
Dwight Moody—Chief of Service—11-27-4
Suzanne Pederson - Vol. Serv. Co. - 12-9-63

GLEN LAKE
Violette Decker— RN II— 11-16-63
Helen E. Larson — RN III — 10-30-63

HASTINGS
Jane Crowley—Staff Physician — 1 2-1 2-63
Joseph Delougherty-Chief of Serv.-11-27-63
Dorothy Grab — Hosp. Soc. Wkr.—11 -13-63
Thomas Jung—Special Tchr. — 11-27-63
Soon Duk Koh—Psychologist II—12-2-63
Velta Mikelsons—Physician II — 10-29-63
Barbara Vandal — RN II — 11-13-63
Hector Zeller— Chief of Serv. — 11-27-63

LINO LAKES
Arthur Ellingsen-Child Care Couns.-11-13-63
Richard Van Zomeran—Child Care Couns. Tr. 10-21-63
Jeanette Wills—Child Care Couns.-l0-28-63

MOOSE LAKE
Wolfgang Selck-Sr.—Staff Physic.—10-21-63

OWATONNA
Clara Crawford -Spec. Sch. Couns. I-10-30-63
Ella Klein—Spec. Sch, Couns. I—10-16-63
Elfrieda Yule-Spec. Sch. Couns. I—10-16-63

ROCHESTER
Frank Heck—Sr. Staff Physic.—11-1-63
Anne E. Wollner—Occ. Thera. I—11-13-63

MINNESOTA SECURITY HOSPITAL
Karen Delesho—RN II—11-6-63
Margaret Laraway—RN II—11-4-63
Fred Roessal—Psycho. II—11-18-63

WILLMAR
Donald Peterson—Staff Physic. — 11-8-63.

Governor Rolvaag and Guests To Tour State Mental Facilities

Gov. Karl F. Rolvaag has announced a series of "Governor's Bus Tours" to state facilities for the mentally ill and the mentally retarded.

The tours will be in cooperation with the Minnesota Association for Mental Health (MAMH) and the Minnesota Association for Retarded Children (MARC).

Rolvaag said the purpose of the tours would be five-fold: to acquaint the members of the tour with new programs, philosophies and facilities in the areas of mental deficiency and mental health; to review progress, observe new developments and become familiar with the areas of need; to focus on "people and programs"; to provide participants with a common experience by which they can observe together and share ideas, concerns and reactions; and to provide a method of communication among key people in the state relative to Minnesota's programs for the mentally ill and mentally retarded.

The governor said that one aspect of the tours which will be of particular value will be overnight stopovers, where the tour members will have dinner meetings with local legislators, civic leaders, members of the MAMH and MARC, and volunteer workers, to discuss local participation in mental health and mental retardation programs.

Each trip will be of two days duration. The governor is inviting approximately thirty-five persons to accompany him and representatives of MARC and MAMH on the bus. These include representatives from the legislature. Medical and Bar associations, business, labor, press, radio and TV, Minnesota Mental Health Planning Council, Minnesota Medical Policy Committee, Citizen's Mental Health Review Committee, National Advisory Mental Health Council, Governor's Advisory Council on Children and Youth, Advisory Council on Handicapped, Gifted and Exceptional Children, Governor's Citizen's Council on Aging, State Division of Vocational Rehabilitation, and the Commissioners of Administration and Public Welfare.

The first tour will take place January 15-16. On January 15 the group will visit the Fergus Falls State Hospital and the Lake Region Sheltered Workshop, and will hear reports from the Lakeland Mental Health Center and the Child Development Center (formerly the 4-County Project). On January 16 they will visit the Brainerd State School and Hospital and the Day Care Center for Retarded Children at St. Cloud.

The second tour will take place February 4-5. On February 4 the group will visit the Moose Lake State Hospital, the Day Care Center, and the Mental Health Center at Duluth. On February 5 they will tour the Cambridge State School and Hospital.

The third tour is scheduled for March 11-12, On March 11 the group will visit St. Peter State Hospital and Faribault State School and Hospital, and on March 12 Rochester and Hastings State Hospitals. Included in the Faribault stop will be a report on Owatonna State School.

The fourth tour, April 1-2, will take the group to Anoka State Hospital, Willmar State Hospital, and the West Central Mental Health Center. On April 2 they will visit the Oak Terrace Nursing Home, the Minnesota Residential Treatment Center at Lino Lakes, and the Hennepin County Mental Health Center,

Mental Health Planning Council Forms Seven Study Committees

Citizen committees to study areas of major concern to the Minnesota Mental Health Program were formed at the second meeting of the Minnesota Mental Health Planning Council November 30 in Minneapolis.

The Planning Council is composed of representatives of approximately sixty agencies, associations, organizations and departments of government with an interest in the field of mental health. Its function is to assist the Minnesota Department of Public Welfare in its task of planning by gathering data, making recommendations, and disseminating information.

Although this is only the second meeting of the entire Council, the Executive Committee met frequently during the Summer and Fall to define more specifically the Council's functions and to design its present committee organization.

Saturday's program included presentations in the morning by Dr. David J. Vail, Director, Medical Services Division, and Dr. C. J. Rowe, Jr., Chairman of the Council, followed by individual sessions of the seven committees.

Members of the Executive Committee serve as chairmen of the committees, and each committee includes one staff member from the Department of Public Welfare.

Following are the names and functions of each committee, and the name and affiliation of the chairman and of the DPW staff person assigned to each committee:

Committee on Economics: To reduce the need for mental hospitalization by means of economic measures. Lester N. Haedt, Minnesota Association of County Welfare Directors; Mrs. Jacqueline Bernard, Research Psychologist, DPW.

Committee on Aftercare: To reduce the need for re-hospitalization. August W. Gehrke, Department of Education; Ardo Wrobel, Rehabilitation Therapies Consultant, DPW.

Committee on Professional Practices: To reduce the need for mental hospitalization by means of enlarged manpower resources and improved professional practices in the community. Walter P. Gardner, M.D., Mental Health Committee of State Medical Associations; Frances Coakley, Supervisor, Mentally Deficient and Epileptic.

Committee on Forensics: To reduce de-socialization and dehumanization occurring in the process of institutionalization. Judge Donald S. Burris, Citizen's Mental Health Review Committee; Robert C. Pfeiler, M.D., Assistant Medical Director, and Galen M. Cadle, Assistant Attorney General, DPW.

Committee on non-medical problems: To reduce problems outside of Medical Services Division accountability areas. Earl J. Beatt, Family and Children's Service; Mrs. Miriam Karlins, Director, Information and Volunteer Services, DPW.

Committee on Facilities: To reduce the need for mental hospitalization by means *of* extra-hospital community facilities. Robert N. Barr, M.D., Minnesota Department of Health; Donald Wujcik, Institution's Administration Supervisor, DPW.

Committee on Institutions; To reduce dehuman-ization within the institution itself. Carl D. Koutsky, M.D, Mental Health Medical Policy Committee: Alvira Hiltz, Institutions Nursing Consultant, DPW.

Anoka Mental Health Study Accumulates Data Essential To Comprehensive Planning

Data collection required for the first phase of the Anoka Menu! Health Study is now 90 percent complete, according to Dr. Arthur Funke, Director, Minnesota Mental Health Study and Planning Program.

The Anoka Study is designed to provide a factual basis for comprehensive mental health planning in Anoka County, and also to test out and demonstrate fact-gathering and interpreting methods which may later be used by other counties for self-study of their own psycho-social problems.

The Anoka Study has been organized in four phases, each dealing with a separate aspect or dimension of the facts required by planners.

Phase I, the Social Epidemiological Study, seeks to determine the size of the problem of social and psychological dysfunctioning by locating and characterizing all persons in the community who are known to one or more Community Agencies or institutions. Three steps are involved: to determine the volume and distribution of existing primary and secondary psycho-social problems; to determine the characteristics of persons having these problems, such as age, sex, whereabouts, family constellation, marital status, impairments, number of problems, and number of problem-episodes; and to determine the characteristics of families having these problems.

Phase II, the Clinical Study, deals with how these problems are being analyzed and treated by the existing social welfare agencies. Five steps are involved; noting the biological, psychological and social characteristics of each case; noting how the agency sets goals for the client, and how it arrives at its prediction of the outcome of the case; noting what resources are needed to achieve the goals; noting how these resources are correlated into an overall treatment plan; and noting how each agency classifies according to goals and to relevant resources.

Phase III, the Agency Study, is concerned with determining how each agency identifies and evaluates its function, and how the various agencies correlate their activities. In regard to the individual agency, seven steps are involved: to identify the agency and its role; to determine the problem or problems which the agency is in business to control and prevent; to determine how the agency formulates its goals; how it measures progress toward its goals; how it sets up specific objectives as steps toward achievement of its goals; and how it provides for implementation, evaluation, and revision of its total program. In regard to inter-agency activity, the Study concerns itself with how the agencies communicate with one another, and how they carry out joint planning and implementation of programs.

Phase IV, the County Study, aims at providing a description of all salient features of life in the community, including physical appearance, history, socio-economic patterns, political structure, and population.

The scope of the study is indicated by the number and variety of reporting agencies. In addition to State Departments of Public Welfare, Health, Education, and Corrections, agencies supplying raw data for the Study include courts, probation and parole authorities, school districts, Veterans Administration hospitals and clinics, coroner, public and private nursing services, private social service agencies, special schools, villages and townships, nursing and rest homes, and a number of other organizations that do not fit into any large category.

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Criteria of Hospital Dehumanization

Based On

Asylums, by Erving Goffman

Goffman's book is an attempt to describe the typical features of life in a "total institution," and to assess the effects which such institutions have on the lives of their inmates.

Examples of "total institutions" are armies, prisons, labor camps, ships at sea, monasteries, and, of course, mental hospitals. Each of these institutions has the following features:

1) A small group of persons controls a large group.
2) Each institution has a specific rationale, or reason for being, which involves remaking the inmate according to a predetermined ideal; inducing a career; killing the Old Adam in order that the New Adam may be born.
3) The entire life of the inmate is spent in the institution.
4) The institutions all engage in "people work," that is, they consciously aim at converting *persons* into *types* that will be better fitted to carry out the aims of the institution.
5) To facilitate conversion, they deliberately employ "mortification," the process of stripping from the inmate all those features which distinguish him from other persons: his role in society, his con- caption of himself and of his personal importance, his mechanisms of self-defense, etc.
6) The internal life of the institution is organized around a system of punishments and rewards which applies to all of the inmate's actions; the inmate is always "under the gun."
7) The institutions are self-perpetuating.

One of Goffman's most useful observations is that frequently what actually goes on in total institutions has very little to do with their rationale—their ideal aims—but is determined instead by expediency and tradition. Administrators are driven to expediency by what he calls the "brute fact of institutional life," the need to take care of many persons in a small space with maximum economy and minimum facilities and staff. Administrators are shackled by tradition, by inertia, by the human tendency to keep a rule in force even when the reason for it has disappeared. Though Goffman severely criticizes mental hospitals, he does not point the finger of blame at any single individual or group. Instead, he merely describes what life in a mental hospital looks like and feels like from the patient's point of view, and leaves it to the reader to draw whatever conclusions seem fit.

In analyzing institutional life as it is actually experienced by the patient, Goffman deals with three processes:

1) The process of "dehumanizing" the patient so that he can be more easily dealt with as just another unit in a "batch."
2) The process of regulating all activities by the "privilege system," which consists essentially of measuring a patient's health in terms of his obedience.
3) The process by which the patient accommodates himself to the actual conditions of institutional life.

Goffman lists many specific features of each of these processes. These features are outlined in the following pages. Staff members in all of Minnesota's hospitals and schools for the mentally ill and retarded are now examining this outline and asking themselves three questions:

1) Does this sort of thing go on in my hospital?
2) If it does, and I approve of it, how do I reconcile this with my theoretical view of the function of a mental hospital?
3) If it does, and I don't approve of it, what have I done to eliminate it or to minimize its bad effect on the patient?

Outline

A. *THE PROCESS OF DEPERSONALIZAT1ON*

1) Is the patient required to sleep, work and play in a restricted number of places, or does he have relative freedom of movement?
2) Is the patient always kept with his "batch", or does he have free choice of his companions?
3) Is he always subject to the same authorities, or does he have some unregulated areas of activity, opportunities for a "moral holiday"?
4) Does staff act primarily in the role of guards?
5) How many specific arrangements are dictated simply by the need to "regulate many by few"?
6) What is done to minimize split between staff and patients?
   a) Any normal social intercourse?
   b) Any use of terms or gestures indicating antagonism or a competition of wills?
   c) Any use of stereotyped designations, names, attitudes (habitual indifferences, loftiness, contempt, etc.)?
7) Are the patients regarded as units for processing?
8) To what extent do we negate the usual motives for work: pay, advancement, prestige, taking care of one's needs? Do we give a patient any reason to feel he should work?
9) Does the amount or nature of the work done bear any relation to the patient's needs, as distinguished from the needs of the institution?
10) To what extent does the patient take responsibility for his own domestic arrangements within the hospital?
11) To what extent do we force him to adjust to "batch" living, and what are our reasons for doing so?

12) Is the patient forced to undergo "role dispossession" (i.e., no longer student, parent, spouse, worker, etc.), at entry?

13) To what extent do we "trim" or "strip" the patient of all features of self-identification?

a) Do we re-identify him by features which he has in common with everyone else?

(1) Stereotyped life history
(2) Photograph
(3) Weight
(4) Fingerprints
(5) Assignment of a number

b) Do we disregard the patient's normal privacies (those to which we feel that we have a right, for instance)?

(1) Searching his person
(2) Removing his personal possessions, and giving him no private locker for storage
(3) Public undressing
(4) Forced bathing and disinfecting

c) Do we reconstitute persons as "units", as identical elements of our system?

(1) Typed haircut
(2) Identical institutional clothing
(3) Group instruction in the rules
(4) Group assignment to quarters, with knowledge that these can be changed any time the staff arbitrarily decides to do so

14} Do we seem to indicate indifference to the "physical integrity" of the patient?

a) Restraint and seclusion
b) Beatings

15) Do we indulge in verbal and gestural humiliation?

a) Tests of obedience
(1) Silly errands
(2) Humiliating movements
(3) Standing at attention
(4) Forced deference: "Sir", etc.

b) Eat all food with spoon, etc.

c) Need to beg for little things which one usually can do for oneself: drink of water, smoke, light, phone

d) Humiliating references to patients: obscene names, cursing: negative criticism, particularly in presence of others; teasing or hazing; discussion of the patient in technical jargon

16) Do we give the patient a daily round of life that is alien to him?

a) No normal heterosexual relationships
b) Make-work, menial jobs

17) Do we deprive the patient of privacy concerning his personal life, his illness, background, etc.?

a) Files open indiscriminately
b) Gossip among staff concerning patients
c) Forced group confessions

18) Do we subject the patient to public humiliations which are not imposed on the staff?

a) Physical examinations lacking privacy
b) Collective sleeping
c) Doorless, partitionless and seatless toilets?
d) Judas windows
e) Constantly with people (no time to be alone)

19) Do we suspend the usual sanitary arrangements?

a) Emptying one's own slop

b) Regimented toilet (as to time, place, and duration of stay)

c) Unclean food
d) Messy quarters
e) Soiled towels or other linen
f) Wearing sweaty clothes of others
g) Dirty bath facilities
h) Sleeping with diseased or dying

20) Are there other invasions of privacy or self respect?

a) Constant surveillance by guards
b) Personal possessions handled by others with out patient's permission
c) Forced grouping without concern for the patient' feelings: on basis of age, race, ethnic group, etc.
d) Use of informal modes of address by strangers or by those who cannot be so addressed by the patient
e) Censoring mail
f) Public visits, no privacy
g) Witnessing mortification of significant others without being able to help

21) Do we create the following conditions?

a) Regimentation: Do only what others are doing

1) Govern all activities by a routine and measured pace

2) Leave no activities to be regulated simply by personal taste

3) Specify minute details of routine: keep hands still, carry only specified items in pocket, use only a specified dole of toilet paper, dress by the numbers, maintain silence, have no pictures or other decorations, do not look around at meals, etc.

b) Tyrannization: do only what others tell you to do

1) Do nothing without permission

2) Be subject to *any* member of the staff, be at anybody's beck and call

22) Do we subject the patient to the "sickness-treatment" rationale of the institution?

a) "Looping"—creating a defensive response, then attacking that response as a symptom of illness
b) Allow no face-saving reactive expressions
c) Interpret *all* actions, even those normally considered indifferent, as signs of illness
d) Perpetuate the diagnosis as a permanent badge

8. *THE PRIVILEGE SYSTEM*

1) Is our definition of rewards and punishments "infantile" and "negative"?
   a) Infantile punishments: not specific punishments for specific misdeeds but diffuse disadvantages which may attach to any action; do we develop in the patient the feeling that "Big Daddy is watching you"?
   b) Negative rewards: rewards are not positive values, but only restorations of normal privileges which are stripped from the patient at time of admission. Do we develop in the patient the feeling that he is dependent on us even for those rights which the rest of us consider "natural" and "inalienable"?

2) Do we identify the question of release with the privilege system? Do we give the patient the feeling that all he has to do to get out is to behave? Do we confuse "conformity to rules" with "mental health"?

3) Do we make the work system part of the privilege system? Do we award easy jobs, etc., to those who "play the game"? In short, is work seen by the patient as punishment or as therapy?

C. *ADAPTIVE PROCESSES*

The processes by which the patient adapts himself to the de-personalization process and to the privilege system:

1) Reactions considered bad in terms of the privilege system:
   a) Withdrawal, regression, etc.
   b) Intransigency, refusal to cooperate with staff

2) Reactions considered good in terms of the privilege system:
   a) Colonization: The patient "settles down" in the institution and makes some sort of free world for himself from the limited materials available,
   b) Conversion: the patient settles down, not because he has made a free world for himself within the institution, but because he has accepted the view that he is totally unable to take care of himself.
   c) "Playing it cool", which combines surface compliance with internal animosity or indifference.
   d) Immunization: the easy-going way of those who have never known any better kind of life than that of the institution.
   e) Identification: becoming a "company man", "stool pigeon", etc.
   f) Special compensations: some patients like the institution because it gives them the closest contact they have ever had with the "polite world" of education, manners, cleanliness, etc.

A basic feature of institutional life as Goffman sees is the fact that the patient is removed from normal society. This means that he is stripped of the privileges to work, sleep and play when, where and with whomever he chooses, under the control only of such authorities as he chooses to recognize, and with large areas of his life subject to no external control whatever. The question asked by those attending the Assembly was this: Do we remove the patient from normal social life because this is good therapy, justifiable in terms of our theory of mental illness?—or simply because we lack the facilities to treat him in his normal environment? Is hospitalization therapeutic, or only expedient?

A second feature of institutional life is dehumaniza-tion, the process of removing from the appearance, behavior and attitudes of the patient all signs of individuality. The question: Is there anything in medical theory that makes this a desirable thing to do?—or is it done simply because patients are easier to handle when they can be regarded as interchangeable units in a "batch?"

A third feature is the tendency of institutions to regulate patients' lives at every instant by the "privilege system," which consists of interpreting every action of the patient as an occasion for administering rewards or punishments. The question: Do we incubate obedience because it is healthful for the patient?—or simply because it is helpful for the harried staff? And even more important, do we judge the patient's mental health by the degree of his conformity to institutional rules, and is such conformity a reliable index of his ability to function in a democratic society?

While admitting the value of asking themselves these questions, staff members also pointed out many ways in which Minnesota's mental health program has already been modified to take advantage of the insights provided by sociology. Having accepted the premise that mental illness is a social disease, we have attempted to attack it on its own grounds through the Community Mental Health Centers, which provide treatment without removing the patient from his normal environment. The Family Rehabilitation Program—basic rationale for all Minnesota welfare activities—assumes that individual problems are inseparable from their social context, and that solutions may require changing the patient's whole environment.

Within the hospitals themselves many steps have been taken to break down the isolation of the patient from normal life: the open-door policy keeps him from feeling incarcerated, and permits him to maintain contacts with family and friends; in hundreds of ways Volunteer programs give him a "touch of home," a chance to participate in community events, and ways to alleviate boredom and loneliness. Patient councils give him an opportunity for self-direction, a voice in governing his own social affairs. Rehabilitation programs within the hospital and in sheltered workshops remind him that he can be a contributing member of society, and give him the needed skills. Convalescent units and other methods of "milieu" therapy place him in an environment as like as possible that of normal life, enabling him to regain self-reliance in easy stages.

In other words, Minnesota's mental hospitals are already to a great extent "social hospitals." Yet the Assembly agreed that much remains to be done.

The Mental Hospital In A Free Society

As we view it, the model of the traditional mental hospital is the feudal manor with overtones of boot camp, Goffman has written brilliantly and incisively on the Total Institution. And this is the way it is. The total institution is characterized by central control; by techniques of indoctrination, an official code, and a system of rewards and punishments through which a small group manages a much larger group; and by a manipulation of the environments which includes all areas of living and human endeavor.

It seems rather that the ideal model of the mental hospital should be the democratic society which has established it. That the goal should be the reduction of social disability by maximizing individual self-responsibility. This is not to beg a basic problem, which is to determine how much responsibility the mentally disordered person is realistically able to develop. Our premise assumes that there is no fixed limit, that through expectation and positive reinforcements one can extend this. How far? At what point does the patient cease being socially unreliable and become reliable again? One can only devise the answers on an individual basis in a system that will allow, that will *really* allow, the person to move along to the maximum extent possible.

The concept of the mental hospital as a democratically administered system, wedded to and inseparable from the postulates of the democratic society which maintains it, is revolutionary. This does not mean that it is exciting, daring, wild-eyed, or original. It means revolution in a true sense that it aims at a redistribution of power, of goods, and of dramatic roles.

According to the theory of Chester Barnard an organization properly includes all those who participate in it. Thus the organization *corporation* includes the stockholders; *department store* includes the customers at any given time; *newspaper* includes the readers. To what extent have mental hospitals really viewed the patient as a part of the organization, as much a part as the head doctor, the plant engineer, or the nursing department? Add to this Kline's pyramidal concept of organization which in value terms would place power at the base rather than the apex of the pyramid. To what extent does the mental patient possess actual power in the organization?

We suggest that power in the mental hospital organization should be distributed to the most basal point—the patient. Who is, after all, the final cause of the entire establishment. From this other possibilities emerge. What about assemblies based on Athenian democratic as well as representative republican principles. With a constitution setting forth officers, government branches and definitions of power. Power to determine what the program should be. Power to have some voice in who should be named head of the medical staff, who should get on the medical staff and who is fit to remain on. (Whatever happened to the "free choice of physician" among the half-million patients in public mental institutions?) For that matter, power to have some voice in determining who should be on the administrative staff. Power through some means to influence the state government itself to reach adequate standards of support.

Patients should be paid for the work they do in institutions. They should then be billed for services received and taxed like anyone else. If they are not paid and one assigns them to work as part of "therapy," then one needs better definitions of '"therapy" than now exist.

Families of patients, and Volunteers, should have greater voice in policy that they now possess.

In summary, we say that there should be a greater approximation of social modes inside and outside the mental hospital. Those whom it purports to serve should have an important role in its management. The work should proceed not on the basis of some arbitrary medical theory, or a self-perpetuating power system to benefit the rulers. It should proceed on the basis of an attempt to identify and solve society's problems, along with all those similarly engaged, using the best instruments available.

—From *"The Mental Hospital In a Free Society,"* by David J. Vail, M.D.

Names in the News

Mr. John Malban, Administrator of Hastings State Hospital has been admitted to the American College of Hospital Administrators, in recognition for outstanding work in his profession.

Dr. Robert Pfeiler, assistant director of Division of Medical Services, has been appointed clinical assistant professor in the department of Psychiatry and Neurology at University of Minnesota.

Appointed by the Governor as delegates to the first state-federal conference on mental retardation at War-rentown, Virginia; *Dr. Richard Bartman,* director of children's mental health services; *Dr. Robert Berglund,* immediate past president of the Minnesota Association for Retarded Children; *Sally Luther,* administrative assistant to the Governor; *Dr. Donald Muhichi,* Iron Range mental health center director; *Dr. Maynard Reynolds,* director of special education, University of Minnesota; *Ellsworth Stenwick,* director of special education division, Minnesota Department of Education; *Gerald F. Walsh,* executive director, MARC; and *Mrs. Donald Kreis,* nursing instructor at Cambridge State School and Hospital. *Mr. Morris Hursh,* Commissioner, Minnesota Department of Public Welfare, will moderate a discussion on public welfare activities in the field of mental retardation.

Selected to attend the annual meeting of the American Association of Volunteer Coordinators, and the fifteenth mental hospital institute of the American Psychiatric Association, both held this month in Cincinnati: *Mrs. Miriam Karlins,* director of public information and Volunteer services, Medical Services Division; *Mr. William Judkins,* assistant director, PIVS; and the following Volunteer Coordinators: *Elenor Clark.* Hastings; J. *H. Johansen,* St. Peter; *Robert Lewis,* Anoka; *Irene Rykken,* Willmar; *Connie Schoen,* Rochester; *Ivalene Heggestad,* Brainerd; *Helen Staubert,* Fairbault. Expenses for this group were met by the Minnesota Mental Health Association and the Minnesota Association for Retarded Children.

Dr. *Carl Koutsky* was recently elected chairman of the Minnesota Mental Health Medical Policy Committee; he is replaced as chairman of the Minnesota Mental Health Planning Council by *Dr. C. J. Rowe, Jr.*

Dr. D. H. Petersen was recently appointed acting director of the alcoholic and drug addiction programs at Willmar State Hospital.

Dr. Howard R. Davis, Chief of Psychology and Research Coordinator gave the keynote address at Minnesota's first leadership conference for action on mental health, held this month in Minneapolis. Others on the program were Dr. *Koutsky; Dr. Frank Kiesler,* director of the Tri-County Mental Health Center, Grand Rapids; *Pearl Mitchell,* Volunteer Services Coordinator, Ramsey County Welfare Department; and *Monsignor J. Richard Feiten,* director of Catholic Charities, Winona.

Dr. Robert Long. Chief psychologist at St. Peter State Hospital was elected to the American Society of Clinical Hypnosis. On August 29, Dr. Long read a paper on the effect of procaine on aged psychiatric patients at the annual convention of the American Psychological Association at Philadelphia.

Dr. Jesse Bollman, director of research at Rochester State Hospital, attended a 10-day International Symposium on Bile in England during September. The meeting was sponsored by the NATO Educational Conference.

CMH Center Lines

More than 350 teachers representing 22 schools in the eight county areas serviced by Lakeland Mental Health Center, Inc., attended a workshop for classroom teachers at the center on August 28. The theme was normal-abnormal development of school children, with emphasis on ways teachers can recognize problems before they become severe.

The Northern Pines Mental Health Center is taking part in faculty workshops in the Eagle Bend Clarissa, Swanville and Browerville school districts.

Pine River has been named site of a monthly "intake" service to be sponsored by the Upper Mississippi Mental Health Center, with headquarters in Bemidji. The new service will be used mainly for preliminary interviewing, testing and diagnosis.

The Northwestern Mental Health Center reported 961 referrals during the past year. Of these, 527 were male and 434 female. Almost half of the cases, 427, were aged 5-15.

Dr. Frederic B. Wilson has joined the staff of the St. Paul-Ramsey County Mental Health Board on half time as neurologist. He is currently in private practice in St. Paul.

Dr. James T. Laird is the new clinical psychologist at the Northern Pines Mental Health Center.

Two psychologists from the Central Minnesota Mental Health Center, Dr. Richard R. Clampitt and Dr. Anthony B. Tabor, are planning to attend the annual meeting of the American Psychological Association in Philadelphia.

Public Health Conference Stresses CMH Center Role

The role of community mental health centers in the total community health program was outlined at the 17th annual conference of the Minnesota Public Health Association September 26-27 in Minneapolis.

Dr. William J. Jepson, program director of the Hennepin County Community Mental Health Center, was chairman of a panel discussion on mental health centers scheduled for afternoon September 26. Preceding discussion, Dr. Robert Pfeiler, assistant director, Medical Services Division, spoke on "The Minnesota Plan for Mental Health Centers", and Dr. Paul W. Wilson, program director of the Rochester-Olmsted County Mental Health Center described "A Mental Health Center's Experience with Public Health and Other Community Services."

Eight Counties Shifted From Anoka District

Eight counties will be shifted from the Anoka State Hospital Receiving District on November 4, 1963 as the first step of a re-districting plan which will put 100 per cent of Hennepin County into the Anoka District by spring of 1964.

Stearns, Benton, and Sherburne Counties will be made part of the Willmar District; Mille Lacs, Kanabec, Chisago, and Isanti counties will be made part of the Moose Lake District; and Washington County will be made part of the Hastings District.

In Spring, 1964 one more county will be taken out of the Anoka District and shifted to the St. Peter District, together with four counties from the Rochester District. All of Hennepin will then go to Anoka.

Fergus Falls Students Write Convincingly About Simple Human Experiences

EDITOR'S NOTE: Those two letters, reprinted from the Fergus Falls State Hospital Bulletin, were written by a teenage boy and girl, Jim Jarvis and Shirley Seary. We think they are written well. They take us past the words into the experience itself. Per-haps you will agree with us that these writers can teach us much about how it feels to be simply and contentedly human.

Boys Camp Out

On Tuesday, August 13th, 16 teenage boys left at 7:30 AM on a camping trip accompanied by Dick Stepp and Ted Olson.

The hike consisted of 6 miles out with their packs and 6 miles without packs.

Jim Jarvis and Kit Larson were the first to arrive at our destination and at noon enjoyed sandwiches and kool-aid.

The first night around 5:30 we set up camp and ate our supper which was cooked by Harvey Swanson, Jim Jarvis, and Randy Olson. Later in the evening we built a council fire, which we sat around and discussed the rules and regulations we were to obey while on the outing, then later we sang songs.

The first morning everyone was up by 7:30. For breakfast we enjoyed a big breakfast consisting of 10 lbs. of ham and pancakes.

After breakfast we went to Lake Jewett where Bob Shelten has his cottage. There we enjoyed fishing. Some of us had forgotten our swimming trunks, therefore had to swim in jeans.

Our dinner consisted of a big pot of Mulligan stew, which was made from 10 lbs. of stewing beef, 2 doz. carrots, and a doz. potatoes with cabbage. Also lots of fruit and coffee.

In the afternoon we went for a 5 mile hike around Dr. Coleman's property.

For supper that evening we ate more Mulligan stew and roasted weiners.

That evening we rode to the take and went swimming, but we hiked back to camp. Then Harvey Swanson and Jim Jarvis threw another log on the fire, which Jim found very useful later, being it was so chilly. He heated a rock in the fire to keep him warm, but it got so hot it took 2 hours to cool enough so he could use it to keep his feet warm.

Four of the boys Jim, John, Dave and Jimmie sat up real late and listened to the Twins' ball game.

The next morning everyone was up by 7:30, as Dick Stepp threatened to pour water on us, and ate a hearty breakfast of bacon and eggs, then packed up our belongings and were on our way back by 10:30.

Girls Camp Out

Last week several young teenage girls from four wards went on a two-day camping trip. Along with the girls were Barbara Sanborn, Beth Hanson, and Kit Darner.

For supper on Tuesday evening we had Mulligan stew which was too hot because it was peppered three different times by three different people.

We had to spray our tents every night, not because of mosquitoes, but flies.

At three in the morning, Sue and Evelyn wanted to fix breakfast, but Barbara said no, that they were making too much noise. They got up at about 5:30 and started the fire going, so we ate at about 7:30.

Later that day, Sue, Sandra, Lelanee, Ramona, Barbara and I went swimming. When we were through, we picked up some shells to give to Sue Mclntyre to use in O.T.

When we returned to camp, I heard that Evelyn had caught *three* fish. We were going to bring them back to show them off to the boys, but they died, so we buried them.

When Dick and Dennis came to pick us up. we had everything piled neatly waiting for them to put it in the truck.

All of us girls would like to thank everyone for taking us.

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